MDR Tracking Number: M5-04-3189-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 5-24-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the work hardening (initial and additional hours) and functional capacity evaluation from 10-1-03 through 10-16-03 were not medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 10-1-03 through 10-16-03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this __9th__ day of September 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

August 25, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-3189-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ------ external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ------ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related injury on ------. The patient reported that while at work he injured his back while lifting boxes. The patient began a treatment program that included traction, adjustments, electrical stimulation, trigger point therapy and ultrasound. On 7/22/03 the patient began a work hardening/conditioning program. The patient presented at the current treating doctors' office after participating in the previous work hardening program because the patient felt he was not improving. On 9/25/03 the patient began the additional work hardening program. The patient completed this program and was released from treatment at his return to work status.

Requested Services

Work Hardening (initial and additional hours) and functional capacity evaluation from 10/1/03 through 10/16/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Request for Reconsideration 3/30/04
2. Office/Progress notes 9/5/03 – 10/21/03
3. FCE 10/16/03

Documents Submitted by Respondent:

1. Position paper 7/16/04
2. SOAP notes 4/1/03 – 10/2/03
3. MRI report 3/27/03

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ------ chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his back on ------. The ------ chiropractor reviewer indicated that the patient went through an extensive amount of treatment without any improvement. The ------ chiropractor reviewer explained that without documented subjective or objective improvement in this

patient's case, further treatment is not medically necessary. The ------ chiropractor reviewer indicated that the patient was recommended for a work hardening program 8 hours a day after he had not responded to a work hardening program 2 hours a day. The ------ chiropractor reviewer explained that the patient attended 9/12 work hardening sessions and was released from the program at the medium work capacity. However, the ------ chiropractor reviewer further explained that the patient did not have a job to return to. Therefore, the ------ chiropractor consultant concluded that the Work Hardening (initial and additional hours) and functional capacity evaluation from 10/1/03 through 10/16/03 were not medically necessary to treat this patient's condition.

Sincerely,